Michigan Department Of Community Health

Bureau Of Health Systems

APPEAL OF A *NOTICE OF AN INVOLUNTARY TRANSFER OR DISCHARGE*

I hereby appeal and request a hearing due to a *Notice of Involuntary Transfer or Discharge* from this facility or a distinct part of the facility.

Please type or print:

Person Requesting Appeal		
Street Address of Person Appealing		
City	State	Zip Code
Daytime Telephone		
Resident		
Facility Name		
Facility Street Address		
City	State	Zip Code
Date Notice Received		
Signature of Person Requesting Appeal **X**		
Date (must be within 10 days of receipt of notice)		
Relationship to Resident Resident Durable Power of Attorney Guardian Other (explain)		

Return completed form to:

Michigan Department of Community Health
Bureau of Health Systems, Division of Operations
Complaint Investigation Unit
P.O. Box 30664 Lansing, Michigan 48909
(Street Address: 611 W. Ottawa Street; Lansing, Michigan 48933)

If you have any questions regarding this procedure you may call the Involuntary Transfer Coordinator with the Division of Operations at (517) 241-4712 or send a fax to (517) 241-0093 for assistance.

BHS-OPS-505 (Rev. 5/04)
Authority: P.A. 368 of 1978 as amended.